



URGENT CARE

7AM - 7PM - 7 DAYS A WEEK

3400 LONG PRAIRIE RD SUITE 102 FLOWER MOUND, TX 75022
P (972) 512-8700 F (972) 512-6020

NAME: _____ DATE: _____

HEALTH QUESTIONNAIRE

Reason for today's visit:

Have you been out of the country in the last 4 weeks? Yes No If yes where? _____

Do you feel like hurting yourself or others today? Yes No (this information will be kept confidential)

Are you using any tobacco products? Yes No Are you Vaping? Yes No

Do you use illicit drugs? Yes No (this information will be kept confidential) if yes, how often: _____

ALLERGIES

List anything that you are allergic to (medications) and how each affects you.

ALLERGY	REACTION
1. _____	_____
2. _____	_____
3. _____	_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins, NSAIDs and inhalers.

DRUG NAME	STRENGTH	FREQUENCY TAKEN
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

PAST MEDICAL HISTORY:

Check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout | <input type="checkbox"/> Leg/Foot Ulcers |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Has Pacemaker | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Clots (or DVT) | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hiatal Hernia or Reflux Disease | <input type="checkbox"/> Pulmonary Embolism |
| <input type="checkbox"/> Claustrophobic | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Reflux or Ulcers |
| <input type="checkbox"/> Diabetes - Insulin | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes - Non-Insulin | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Overactive Thyroid | <input type="checkbox"/> Other (please explain below) |

(WOMEN ONLY)

Are you pregnant? _____ Are you nursing? _____

Patient, Parent, or Guardian Signature: _____